REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **The Chief Executive of South Western Ambulance Service** **Chief Constable of the Devon and Cornwall Police**
1	**CORONER** I am Senior Coroner for the coroner area of Cornwall
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3	**INVESTIGATION and INQUEST** **The inquest into the death of William Robert Raymond Nute was opened on 25th February 2016 after an investigation was opened on the 17th July 2015. Mr Nute was born on the 6th April 1931 and died on the 2nd July 2015. An inquest was held at 1.00 pm on 2nd March 2016**
4	**CIRCUMSTANCES OF THE DEATH** William Nute had come out the Spar shop with his shopping in Tintagel where he lived. He was crossing the loading bay near the Spar Shop, Fore Street, Tintagel when he fell while a Ford Focus car registration number ML15 2RY was reversing in his direction at around 11.45 am on 30th June 2015. It was not clear whether the car hit Mr Nute or how he fell. An ambulance was called at around 11.45 detailing that Mr Nute had been hit by a car (log attached) but despite a target response time of 30 minutes the first ambulance resource did not arrive until 12.35. On arrival an ambulance was requested at 12.40 but despite a response time of 30 minutes did not arrive until 1.44 pm. For reasons unknown, Mr Nute did not arrive at the Royal Cornwall Hospital, Treliske, Truro until 16.14 pm. He was admitted and diagnosed with a fractured neck of femur. Due to his immobility, the stress on his existing heart disease and the fractured neck of femur he developed pneumonia. He deteriorated and died on 2nd July 2015. The pathologist gave the cause of death 1a pneumonia 1b immobility and congestive cardiac failure 1c Fractured neck of femur (not operated) II Chronic kidney disease and the inquest concluded that Mr Nute died as a result of an accident.

	The South Western Ambulance representative gave evidence that the reason that they attended outside their target times was because of a high demand on the service at that time. She was satisfied that all efforts were made to locate resources and there were no lost opportunities. Despite the fact that the ambulance service had been informed at around 11.45 am on 30th June that Mr Nute had an injury as a result of being hit by car, the police were not informed until 12.55 and they did not attend until 13.14 pm. The result was the Mr Nute an elderly gentleman of 84 was left lying on a public highway (albeit in a layby) from 11.45 to at least 1.44 pm in the heat without emergency service support despite repeated calls from the public who were concerned for his welfare and dignity. Both the pathologist and treating doctor gave the opinion that the delay in transfer to hospital did not assist his recovery from the fall.
5	**CORONER'S CONCERNS** During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths will occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows. – • That the delay in attending and transferring Mr Nute increased his risk of not recovering from his fall/fracture or the trauma of the incident which in turn increasing his risk of death. • That the 999 calls from the public were not triaged by the call handlers at BT or South Western Ambulance appropriately and managed. • That South Western Ambulance did not inform the police of a road traffic accident in a timely fashion resulting in the scene of the incident/patient and late arrival of the ambulance not being managed appropriately. For example the witnesses to the road traffic accident were left waiting a good number of hours for the police to arrive to provide their details to them and there was no one to professionally manage the safety/dignity of Mr Nute who was lying on the highway.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you [AND/OR your organisation] have the power to take such action. To review to the triage of 999 incidents by BT and SW Ambulance and the Devon and Cornwall Police to ensure an appropriate managed response. To review the working relationship between SW ambulance and the Devon and Cornwall Police in information sharing so that resource delays can be managed appropriately – especially at busy time and to consider the use of back up resources when needed.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by the 19th July 2016. I, the coroner, may extend the period. Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise you must explain why no action is proposed.
8	**COPIES and PUBLICATION**

	I have sent a copy of my report to the Chief Coroner and to the following Interested Persons [redacted] [redacted] Robertson & Co, [redacted] Investigation Bureau, and [redacted] Cormac and to the LOCAL ADULT SAFEGUARDING BOARD. I am also under a duty to send the Chief Coroner a copy of your response. The Chief Coroner may publish either or both in a complete or redacted or summary form. He may send a copy of this report to any person who he believes may find it useful or of interest. You may make representations to me, the coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.	
9	**[DATE]** **24.05.16**	**[SIGNED BY CORONER]** Elizabeth Emma Carlyon